St. Edmund Preparatory High School
Office of Medical Services

Kathryn DeMello, RN
School Nurse

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Dear Parent/Guardian,

The New York Public Health Law & St. Edmund Prep policy mandates that any new entrant must submit ALL of the following in order to attend school.

____ A completed medical evaluation
(must include height, weight, blood pressure, medical history, a developmental assessment, anemia screening, vision, hearing, dental screening)

Medical evaluations <u>must have been done within 12 months of admission.</u> (September 1, 2019)

Medicals expire one year from the date of exam. If a student is playing sports, a new medical is required every year. A medical clearance card (a.k.a. blue card) will only be issued with a current medical on file.

<u>Please note the permission for Tylenol/Advil at the top of the form under student's name. This must be signed in order for the student to receive them during school hours. Permission over the phone is not an option</u>

____ 4 doses of Diphtheria vaccine (DtaP or DTP or DT)
____ 1 dose of Tetanus, Diphtheria, Pertussis vaccine (Tdap) (given after age 7 years)
____ 4 doses of Polio vaccine (OPV or IPV)
____ 2 doses of Measles, Mumps, and Rubella vaccine (MMR)
(1 dose given on or after the 1st birthday, and the 2nd at least 28 days after the 1st & at or after age 15 months)
____ 3 doses of Hepatitis B vaccine
____ 2 doses of Varicella vaccine *(given on or after the 1st birthday)*
____ 1 dose of Meningococcal vaccine (MCV4)

The form on the back of this letter must be **signed and mechanically stamped** by your physician and returned to school by **August 1, 2019**. **** NO OTHER FORM WILL BE ACCEPTED****

If you have any questions, please feel free to call me at (718) 743-6100 ext. 5062 during regular school hours. My summer hours are Thursdays only from 9:00 AM to 12:00 noon.

Sincerely,

Kathryn DeMello R.N.

ST. EDMUND PREPARATORY HIGH SCHOOL
HEALTH CERTIFICATE / APPRAISAL FORM

Name: ______________________ **Date of Birth:** ______________________

I give permission for my child to be given Tylenol or Advil in the event of minor headaches, aches or pains Yes No

Parent Signature ______________________

IMMUNIZATIONS

DPT/DTaP/DT __/__/__ __/__/__ __/__/__ __/__/__ __/__/__ __/__/__ Tdap __/__/__ Td __/__/__ __/__/__ MMR __/__/__ __/__/__

IPV/OPV __/__/__ __/__/__ __/__/__ __/__/__ __/__/__ HepB __/__/__ __/__/__ __/__/__ __/__/__ Varicella __/__/__ __/__/__ Disease____

Hib __/__/__ __/__/__ __/__/__ __/__/__ HepA __/__/__ __/__/__ HPV __/__/__ __/__/__ __/__/__ Meningococcal__/__/__ __/__/__

Other(specify with dates)______________________

Significant Medical/Surgical History: ❒ See attached ______________________

Allergies: ❒ **LIFE THREATENING** ❒ Food: __________ ❒ Insect: __________ ❒ Other: __________

❒ Seasonal ❒ Medication: __________

PHYSICAL EXAM

Height: __________ Weight: __________ Blood Pressure: __________ Date of Exam: __________

Body Mass Index: ______ ______ . ______	Vision - without glasses/contact lenses	R	L	Referral
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th	Vision - Near Point	R	L	
❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher	Hearing ❑ Pass 20 db sc both ears or:	R	L	

❒ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ❒ Negative ❒ Positive: __________

Specify any abnormality______________________

MEDICATIONS

Medications (list all): ❒ None Child may be given Tylenol/Advil in the event of minor headaches, aches and pains. ______Yes ______No

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❒ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**

___ Limited contact: cheerleading, gymnastics, skiing, volleyball, cross-country, handball, fencing, baseball, floor hockey, softball.

___ Non-contact: badminton, bowling, golf, swiming, table tennis, tennis, archery, riflery, weight training, crew, dance, track, run, walk, rope jump.

❒ **Specify medical accommodations needed for school**: ______________________ ❒ None

❒ **Known or suspected disability:** ______________________ ❒ Please monitor

❒ **Restrictions:** ______________________ ❒ Please monitor

❒ **Protective equipment required:** ❒ Athletic Cup ❒ Sport goggles/impact resistant eyewear ❒ Other: __________

OPTIONAL INFORMATION, if known

Specify current diseases: ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hyperlipidemia ❒ Hypertension

❒ Other: ______________________

Provider's Signature: ______________________ Phone: __________ (MUST BE STAMPED)

Provider's Name/Address: ______________________ Fax: __________

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.